STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155530	A. BUILDING 00 B. WING	09/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH SHORE HEALTH & REHABILITATION CENTER	353 TYLER ST GARY, IN 46402

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00180655. This visit resulted in an Extended Survey-Immediate Jeopardy. Complaint IN00180655-Substantiated. Federal/State deficiencies related to the allegations are cited at F166 and F309. Survey dates: September 14, 15, 16, and 17, 2015 Extended Survey dates: September 18, 19, 20, 21, and 22, 2015 Facility number: 000369 Provider number: 155530 Aim number: 100275190 Census bed type: SNF/NF: 72 Total: 72 Census payor type: Medicare: 13 Medicaid: 58 Other: 1 Total: 72	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 26143, On September 28, 2015.			
F 0159 SS=D Bldg. 00	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.			

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	The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. Based on record review and interview, the facility failed to ensure residents had access to their money on weekends, received quarterly statements, and received interest on their funds for 2 of 4 residents reviewed for personal funds of the 4 residents that met the criteria for personal funds. (Residents #82 & 71) Findings include: 1. Interview with Resident #82 on 9/14/2015 at 10:23 a.m., indicated he was not able to get any money from his personal funds account on the weekends. He further indicated the funds were only available on Monday, Wednesday, and Friday.	F 0159	Format for plan of Correction F 159 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1.Resident# 82: Business office manager spoke with resident to let resident know of thechanges in the system as it relates to banking hours and disbursement policy. 2.Resident# 71: Residents son was handed a statement for September and made aware that statements will be sent monthly for the balance of 2015 and then quarterly starting January 1, 2016. 2.How other residents having the potential to be affected by the same deficient practice will be	10/22/2015

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	Interview with the Resident Council President on 9/17/15 at 10:05 a.m., indicated residents get their money on Monday, Wednesday and Friday. When asked if they could get money on Tuesday or Thursday, he was not aware. Interview with the Business Office Manager on 9/16/2015 at 12:05 p.m., indicated the residents have access to their personal funds during the week. She further indicated the business office disbursed funds to the residents on Monday, Wednesday, and Friday but the residents were able to request funds any day. During the weekends the Medical Records Assistant would be available for disbursement. Interview with the Administrator on 9/17/2015 at 1:45 p.m., indicated that a sign was not posted anywhere in the facility with the banking hours. He further indicated he was aware the Business Office Manager had posted a sign at the front of the facility this morning with business office hours. 2. Interview with Resident #71's son on 09/15/2015 at 12:09 p.m., indicated he had not received a personal funds statement from the facility.		identified and what corrective action(s) will be taken ; 1.All residents have the potential to be affected by the same deficient practice. 2.All residents will be informed at Resident Council meeting October 15, 2015 thatthe statements will be sent monthly for the balance of 2015 and quarterlystarting January 1, 2016. Any resident not in attendance will also be notified. 3.What measures will be put in place or what systemic changes will be made to ensurethat the deficient practice does not recur; 1.Residents personal fund statements will be sent out monthly for the balance of 2015 and quarterly starting January 1, 2016. 2.Bankinghours have been changed to Sunday through Saturday 11:00 am to 1:00 pm. Fundsare always available upon request. Hours are posted at the admission window. 3.Interestwill be applied monthly by the resident trust software program to the residentstrust account. The account has been updated to present. 4.In-service has conducted to all Business Office staff on October 5, 2015. 4.Howthe corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place ;	

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	Review of Resident #71's personal funds account with Business Office Manager on 9/17/2015 at 2:15 p.m., indicated no statement had been mailed or given to the resident or family member because he had not requested a statement. Interview with Business Office Manager on 9/17/2015 at 2:25 p.m., indicated she only printed out statements when requested by residents or family, and that she did not just mail them out. 3. Review of Resident's #82 and #71 personal funds account with Business Office Manager on 9/17/2015 at 2:19 p.m., indicated she was unable to locate where any interest had been applied to the residents' personal funds account since January 2015. While reviewing each of the above resident's accounts and statements on her computer, she indicated since June the bank statements had been going to the Corporate office, and she contacted them and the statements would be sent to the facility for the interest to be processed. 3.1-6(c) 3.1-6(f)(1) 3.1-6(g)		1.The resident trust fund will be monitored monthly by the Business Office manager/and or designee. 2.Theaudit will be conducted monthly and reported to the QAPI monthly for 6 months. 5. By what date the systemic changes will becompleted October 22, 2015 6.This Plan of Correction constitutes my written allegationof compliance for the deficiencies cited. However, submission of this Plan ofCorrection is not an admission that a deficiency exists or that one was citedcorrectly. This Plan of correction is submitted to meet requirementsestablished by state and federal law.	
F 0166	483.10(f)(2)			

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SS=D Bldg. 00	RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. Based on record review and interview, the facility failed to ensure all grievances filed by family members were followed up on as per the facility's policy for 1 of 1 residents reviewed for grievances. (Resident #B) Finding includes: The closed record review for Resident #B was completed on 9/15/15 at 2:44 p.m. The resident was admitted to the facility on 6/10/15. The resident's diagnoses included, but were not limited to, chronic bronchitis, scarring of the lung, tobacco use, cachexia (a wasting syndrome such as a loss of weight or muscle) associated with pulmonary fibrosis, lung cancer, and unintended weight loss. A complaint and grievance report dated 6/10/15 that was found in the resident's closed record, indicated "Family said receiving nurse on days RN #3 (name of nurse) made them feel as though it was a bother caring for or asking questions regarding (resident name). They felt more at ease once LPN #5 (name of nurse) started his shift. Said he was very	F 0166	Format for plan of Correction F 166 1.What corrective action(s) will be accomplishedfor those residents found to have been affected by the deficient practice; 1.Resident # B had been discharged therefore no actioncan be taken at this time 2.How other residents having the potential to beaffected by the same deficient practice will be identified and what correctiveaction(s) will be taken ; 1.Allresidents have the potential to be affected by this deficient practice and allinterviewable residents will be queriedto determine if any have complaints or concerns that need to be addressed 2.Allresponsible parties will be called or interviewed to determine if they have anycomplaints or concerns that need to be addressed. 3.At themonthly resident council meeting the residents will have the opportunity tovoice concerns and such concerns will be logged in the grievance log forreview. 4.Allresidents and or responsible parties will be informed of grievance procedureupon admission and	10/22/2015

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	good, great bedside manner. Family made call to social worker at hospital regarding the situation on 6/11/15." The complaint was taken by the Admission Director at the facility. Continued review of the complaint and grievance report indicated nothing else had been completed on the report. Interview with the Interim Director of Nursing (DoN)/Nurse Consultant on 9/17/15 at 7:30 a.m., indicated the complaint/grievance from the resident's family dated 6/10/15 was not acted on. The current 5/23/15 Registration and Disposition of Resident Complaints Policy provided by the Interim DoN/Nurse Consultant indicated the purpose of the policy was "To ensure residents and families have the opportunity to have complaints heard reviewed and when possible, receive resolution and/or appropriate disposition. Any facility staff member receiving a concern is responsible to report the concern to their supervisor and or contact the Social Service Director. Upon receipt of the grievance, the Administrator will review, assure that the concern has been investigated and resolved." Interview with Interim DoN/Nurse		such policy is posted in facility. 3.What measures will be put in place or whatsystemic changes will be made to ensure that the deficient practice does notrecur; 1. Current Grievance policy has been reviewedand revised as needed 2.Staffwill be re-in-serviced on the current Grievance policy and procedure 3.Grievanceswill be reviewed at morning meeting 4.Grievancelog will be updated weekly 4.How the corrective action(s) will be monitoredto ensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place ; 1.Grievancelog will be audited monthly by the Business Office Manager/designee for six months then reviewed as part of the monthlyQAPI meeting on going or on as need basis. 2.Reportof audits will be presented to QAPI meeting monthly 5.By what date the systemic changes will becompleted October 22,2015 6.This Plan of Correction constitutes my written allegationof compliance for the deficiencies cited. However, submission of this Plan ofCorrection is not an admission that a deficiency exists or that one was citedcorrectly. This Plan of correction is submitted to meet	

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	Consultant on 9/20/15 at 5:22 p.m., indicated the Administrator had never received the grievance from the Admissions Director. This Federal Tag relates to Complaint IN00180655. 3.1-7(a)(2)		requirementsestablished by state and federal law.	
F 0225 SS=D Bldg. 00	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly			

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	investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on record review and interview, the facility failed to ensure 1 of 1 allegations of resident to resident abuse of the 3 allegations of abuse reviewed, was reported to the State Agency. (Resident #2) Finding includes: Interview with Resident #2 on 9/15/15 at 10:58 a.m., indicated that she had been hit by a male resident several months ago. The record for Resident #2 was reviewed on 9/15/15 at 2:40 p.m. The Nursing progress notes dated 6/23/15 at 10:20 a.m., indicated the resident was involved in an incident and was on 15 minute checks. The Social Service progress note dated 6/23/15 (no time), indicated the Social	F 0225	Format for plan of Correction F 225 1.What corrective action(s) will be accomplishedfor those residents found to have been affected by the deficient practice; 1.Resident# 2 incident occurred on 6/23/2015 and at this time has had no furtherincidents of allegation of abuse. 2.How other residents having the potential to beaffected by the same deficient practice will be identified and what correctiveaction(s) will be taken ; 1.Allresidents have the potential to be affected by this deficient practice. 2.Areview of incident reports was conducted and there has only been one residentto resident allegation of abuse and each resident's incident was reported on10/03/2015 3.What measures will be put in place or whatsystemic changes will be made to ensure that the deficient practice does notrecur;	10/22/2015

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	Service Director was informed of an occurrence between the resident and her peer. Interview with the Interim DON/Nurse Consultant on 9/16/15 at 9:40 a.m., indicated the two residents were in the Main Dining Room, when Resident #2's hand was hit by a male resident. The Interim DON/Nurse Consultant indicated the previous DON was instructed by the Administrator to report the resident to resident altercation to the State Department of Health, however, she did not report the allegation as requested. 3.1-28(c)		1. A review of reportable policy was completedand revisions made as necessary. 2.Administratorand Director of Nursing will send all incident/accident reports for review toCompliance Committee 3.Administratorand Director of Nursing will be re-in-serviced by the Corporate Complianceofficer as it relates to resident /resident allegation of abuse policy. Thein-service was completed on October 9, 2015. 4.How the corrective action(s) will be monitoredto ensure the deficient practice will not recur, i.e., what quality assuranceprogram will be put into place ; 1.Thereportable log will be revised to include room for Director of Nursing andAdministrator signatures and log will be reviewed at regularly scheduledCorporate Compliance meetings. 2.This procedure will be ongoing 5.By what date the systemic changes will becompleted October 22, 2015 This Plan of Correction constitutes my written allegationof compliance for the deficiencies cited. However, submission of this Plan ofCorrection is not an admission that a deficiency exists or that one was citedcorrectly. This Plan of correction is submitted to meet	

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			requirementsestablished by state and federal law.	
F 0226 SS=D Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure their Abuse Policy and Protocol was followed related to the lack of investigation as well as reporting 1 of 1 allegations of resident to resident abuse of the 3 allegations of abuse reviewed. (Resident #2) Finding includes: Interview with Resident #2 on 9/15/15 at 10:58 a.m., indicated that she had been hit by a male resident several months ago. The record for Resident #2 was reviewed on 9/15/15 at 2:40 p.m. The Nursing progress notes dated 6/23/15 at 10:20 a.m., indicated the resident was involved in an incident and was on 15 minute checks. The Social Service progress note dated 6/23/15 (no time), indicated the Social Service Director was informed of an	F 0226	Plan of Correction F 226 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1.Resident # 2 incident occurred on 6/23/2015 and atthis time has had no further incidents of allegation of abuse. 2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken ; 1.All residents have the potential to be affected by this deficient practice. 2.Are view of incident reports was conducted and there has only been one residentto resident allegation of abuse and each resident incident was reported. 3.What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur; 1. A review of reportable policy was completed and revisions made as necessary.	10/22/2015

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	occurrence between the resident and her peer. Interview with the Social Service Director on 9/16/15 at 3:42 p.m., indicated she didn't remember specific details about the incident between the residents, she thought the male resident hit Resident #2. She indicated she interviewed other residents and they had no problems with any of the residents. Interview with the Interim DON/Nurse Consultant on 9/16/15 at 9:40 a.m., indicated the two residents were in the Main Dining Room, when Resident #2's hand was hit by a male resident. The Interim DON/Nurse Consultant indicated the previous DON was instructed by the Administrator to report the resident to resident altercation to the State Department of Health, however, she did not report the allegation as requested. The Interim DON/Nurse Consultant also indicated at this time that staff and resident interviews were conducted but the book containing all of the abuse investigations had been taken from the facility. Review of the facility's Abuse Prevention Program Facility Policy on 9/16/15 at 9:00 a.m., which was provided by the Interim DON/Nurse Consultant and		2.Administrator and Director of Nursing will send all incident/accident reports for review to compliance committee 3.Administratorand Director of Nursing will be re-in serviced by the Corporate Compliance Officer as it relates to resident /resident allegation of abuse policy. The in-service was completed on October 9, 2015. 1.How the corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place ; 1.The reportable log will be revised to include room for Director of Nursing and Administrator signatures and log will be reviewed at regularly scheduled Corporate Compliance meetings. 2.This procedure will be ongoing. 1.By what date the systemic changes will be completed October 22, 2015 This Plan of Correction constitutes my written allegationof compliance for the deficiencies cited. However, submission of this Plan ofCorrection is not an admission that a deficiency exists or that one was citedcorrectly. This Plan of correction is submitted to meet requirementsestablished by state and federal law.	

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	identified as current, indicated the following: "Initial Reporting of Allegations: Once the Administrator has been notified of an allegation of mistreatment, abuse or neglect, injury of unknown origin or misappropriation of resident property the Administrator will report to the Indiana State Department of Health immediately. The report shall be made as soon as possible but, ought not exceed 24 hours after discovery of the incident." "Once the administrator is notified of possible mistreatment, abuse or neglect, injury of unknown origin, or misappropriation of resident property the administrator will initiate or appoint a person to take charge of the investigation. The person in charge of the investigation will obtain a copy of any documentation relative to the incident, and the Resident Protection Investigation Procedures. The appointed investigator will follow the Resident Protection Investigation Procedures attached to this policy. The Procedures contain specific investigation paths depending on the nature of the allegation, and procedures for investigation, interview parameters, and reporting requirements." 3.1-28(d)			

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F 0241 SS=D Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review, and interview, the facility failed to ensure the resident's dignity was maintained related to not referring to a dependent resident as "honey" or "baby" for 1 of 1 residents reviewed for dignity of the 1 resident who met the criteria for dignity. (Resident #71) Finding includes: 1. On 9/16/2015 at 9:01 a.m., CNA #1 was overheard saying "okay baby" as she left Resident #71's room. On 9/17/2015 at 8:31 a.m., CNA #2 was overheard speaking to the resident, saying "you okay honey, I'll be right back honey." The resident was the only person in her room at that time. On 9/16/2015 at 8:22 a.m., Resident #71's record was reviewed. Diagnosis included, but were not limited to,	F 0241	Format for plan of Correction F 241 1.What corrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; 1.Resident#71: Is able to shake head yes and no to respond to question and Social Serviceinterviewed her to determine how she would like to be addressed. 2.Resident# 71: A care plan meeting has been scheduled with son to discuss interview withresident and to have the opportunity to share his mothers' preference of how she prefers to be addressed. 2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken ; 1.All Residents have the potential to be affected by the same deficient practice. 2.All residents that can participate in an interview will be asked their preferencein being	10/22/2015

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	hemiparesis, hypertension, expressive aphasia, anxiety, depression with depressed mood, vascular dementia, and cerebrovascular accident. Interview with the Resident's son on 9/15/2015 at 12:04 p.m., indicated the staff speak to his mother like a child. Interview with CNA #2 on 9/17/2015 at 8:33 a.m., indicated she calls all her residents honey. 3.1-3(t)		addressed by Social Services and Care Plan will be updated to indicatepreference 3.SocialServices will contact responsible party for resident who are unable to beinterviewed. 3.What measures will be put in place or what systemic changes will be made to ensurethat the deficient practice does not recur; 1.InService was conducted on Dignity and Respect and Resident Rights on October 8,2015. 4.How the corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place ; 1.Monthly audits will be conducted three times aweek that will include all three shifts and this will be conducted for six months. The Social Services director/designee will be responsible for audits. 2.Findingsof monthly audit will be presented at QAPI meetings. 5.By what date the systemic changes will becompleted October 22,2015 This Plan of Correction constitutes my written allegationof compliance for the deficiencies cited. However, submission of this Plan ofCorrection is not an admission that a deficiency exists or that one was citedcorrectly. This Plan of correction is submitted to meet requirementsestablished by state and federal law.	

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F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to ensure Physician's orders were followed as written related to medication administration for 1 of 5 residents reviewed for unnecessary medications. (Resident #55) Finding includes: The record for Resident #55 was reviewed on 9/16/15 at 9:10 a.m. The resident's diagnosis included, but was not limited to osteoporosis. A Physician's order dated 1/13/15, indicated the resident was to receive Fosamax (a medication used to treat osteoporosis) 70 milligrams (mg) one tablet by mouth once weekly 30-60 minutes prior to food/drink/meds with 8 ounces of water and remain upright for 30 minutes and until first food of the day. The July 2015 Medication Administration Record (MAR), indicated the resident received only one dose of the Fosamax for the month on July 16, 2015.	F 0282	Format for plan of Correction F 282 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1.Resident# 55 Medication is present (Fosamax) and has been administered on October 2,2015 and is scheduled weekly. 2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken ; 1.All residents' physician orders have been reviewed and findings addressed. All current Physician orders are on MAR and TAR and all medications are available. 3.What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur; 1.Nurses will be re-in serviced on following physician orders 2.All new physician orders will be placed on 24 hour report sheets 3.All new physician orders will be reviewed by DON /or Designee 4.How the corrective action(s)	10/22/2015

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	The August 2015 MAR, indicated the resident did not receive the Fosamax the entire month. The September 2015 MAR, indicated the resident did not receive the Fosamax on 9/11/15 as ordered. Interview with the Interim DON/Nurse Consultant on 9/17/15 at 2:50 p.m., indicated the resident had not received her Fosamax as ordered since July 2015. 3.1-35(g)(2)		will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place ; 1.Compliance with physician order audits will be done daily for 2 months ,weekly for 2months , and bi- weekly for 2 months on-going. 2.DON/designee will be responsible for completing the audits 3.Auditfindings will be presented at QAPI meeting By what date the systemic changes will becompleted October 22,2015 This Plan of Correction constitutes my written allegationof compliance for the deficiencies cited. However, submission of this Plan ofCorrection is not an admission that a deficiency exists or that one was citedcorrectly. This Plan of correction is submitted to meet requirementsestablished by state and federal law.	
F 0309 SS=G Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure each resident received the necessary treatment and	F 0309	Plan of Correction F - 309 1.What corrective action(s) will be accomplished for those residents found to havebeen	10/22/2015

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	services related to identifying a significant change of condition for a resident who stopped eating, and had a decline in respiratory status that led to a hospitalization for 1 of 1 residents reviewed for hospitalization. (Resident #B) Finding includes: The closed record review for Resident #B was completed on 9/15/15 at 2:44 p.m. The resident was admitted to the facility on 6/10/15 and discharged to the hospital on 6/12/15. The resident did not return back to the facility. The resident's diagnoses included, but were not limited to, chronic bronchitis, scarring of the lung, tobacco use, cachexia (a wasting syndrome such as a loss of weight or muscle) associated with pulmonary fibrosis, lung cancer, and unintended weight loss. Hospital Progress Notes dated 6/7/15 indicated the resident's weight was 119 pounds. He had a fluid intake on 6/7/15 of 1163 milliliters (ml). A Comprehensive Metabolic Panel (CMP) was drawn. The resident's Blood Urea Nitrogen (BUN) was 27 (normal was 8-23) and the Creatine (CR) was .3 (normal level .7-1.2). The resident's assessment of lungs was normal breath		affected by the deficient practice; 1.Resident# B is no longer in the facility. 2.How other residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken ; 1.Allresidents medical records have been reviewed, interviews with nurses, physicianand using the RAI manual definition of significant change was used to identifyif any other resident met this criteria. 2 residents were identified. 1.1 in amedical decline and referred to hospice 2.1resident experiencing generalized weakness was referred to physical therapy forscreening. 3.What measures will be put in place or what systemic changes will be made to ensurethat the deficient practice does not recur; 1.Significantchange policy was reviewed and revised as needed 2.Anin-service regarding significant change will be presented to nurses. 4.How the corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place ; 1.Allsignificant changes will be documented on the 24 hour report sheet 2.AnAudit of the 24 hour report will be completed daily by	

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	sounds, no respiratory distress, no wheezing, no chest tenderness. The resident was alert and oriented times three and had normal motor function and normal sensory function. The Discharge Summary dated 6/10/15 indicated the patient was admitted with a diagnosis of acute exacerbation of COPD pulmonary fibrosis, acute and chronic exacerbation of bronchitis, leukocytes, and weight loss. During the course of his hospital stay unfortunately he was also diagnosed with metastatic cancer. He was found to have adenocarcinoma (a type of cancerous tumor that occurs in several parts of the body) with tumors to the liver and lungs. After being seen by oncology it was determined he was too weak for chemotherapy and might be better with hospice. He was stable for discharge from his medical bed and was transferred to a skilled nursing facility. The list of current medications to be taken was Budesonide (a medication used to treat COPD) .5 mg neb solution take 2 mls by neb twice a day and Ipratropium Albuterol (a combined medication used to treat COPD) .5-2.5 (3) milligram (mg)/3 ml solution take 3 ml by neb every 4 hours. Physician Orders dated 6/10/15 indicated: Alprazolam (Xanax an Antianxiety) .5		DON /or designee andthis will be ongoing. 3.Audit finding will be presented to QA on an ongoing basis. 5. By what date the systemic changes will becompleted Plan of Correction F - 309 1.Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; 1.Resident# B is no longer in the facility. 2.Howother residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken ; 1.All residents medical records have been reviewed, interviews with nurses, physicianand using the RAI manual definition of significant change was used to identifyif any other resident met this criteria. 2 residents were identified. 1.1 in amedical decline and referred to hospice 2.1resident experiencing generalized weakness was referred to physical therapy forscreening. 3.What measures will be put in place or what systemic changes will be made to ensurethat the deficient practice does not recur; 1.Significantchange policy was reviewed and revised as needed 2.Anin-service regarding	

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	mg 1 three times a day for 30 days. Budesonide .5 mg neb solution take 2 mls by neb twice a day and Ipratropium Albuterol .5-2.5 (3) milligram (mg)/3 ml solution take 3 ml by neb every 4 hours. Morphine Sulfate 30 mg 1 tab twice a day for 15 days There was no current order for continuous oxygen A Complete Blood Count (CBC) and a CMP was to be drawn on 6/11/15 then every month. The lab data was reviewed and there was no evidence the above labs were drawn. The Nursing assessment dated 6/10/15 indicated the resident weighed 109 pounds. Nursing Progress Notes dated 6/10/15 at 2:45 p.m., indicated the resident was admitted to the facility. The resident was assessed as having labored breathing with substernal retractions. The resident also indicated he could not breathe. A Respiratory assessment completed by a Respiratory Therapist at the facility, dated 6/10/15 indicated the resident was visibly short of breath with severe substernal retractions. The resident was instructed on pursed lip breathing and		significant change will be presented to nurses. 4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place ; 1.All significant changes will be documented on the 24 hour report sheet 2.An Audit of the 24 hour report will be completed daily by DON /or designee and this will be ongoing. 3.Audit finding will be presented to QA on an ongoing basis. 5. By what date the systemic changes will be completed October 22,2015 This Plan of Correction constitutes my written allegationof compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of correction is submitted to meet requirements established by state and federal law.	

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	was only able to speak in short phrases. The Respiratory Therapist recommended the following: Duoneb 3 ml nebulizer treatment every 4 hours. Pulmicort .5 mg/2 ml nebulizer treatment twice a day. Albuterol 2.5 mg/3 ml nebulizer treatment every 2 hours prn (as needed) for increased shortness of breath. Physician Orders dated 6/10/15 indicated all of the above recommendations were transcribed onto Physician Orders to be implemented. The Medication Administration Record (MAR) was reviewed for 6/10/15. The Albuterol 2.5 mg/3 ml nebulizer treatment every 2 hours prn for increased shortness of breath was not transcribed onto the med sheet. Continued review of the MAR indicated the following: there were no meds or nebulizer treatments signed out on 6/10/15. The Ipratropium/Albuterol treatment to be given every 4 hours was signed out as being administered on 6/11/15 at 5:00 a.m., 9:00 a.m., 1:00 p.m., and 5:00 p.m. The 9:00 p.m. and 1:00 a.m. times were blank. That same nebulizer treatment was signed out on 9:00 a.m., and 1:00 p.m. only for 6/12/15. The administration times were 1:00 a.m., 5:00 a.m., 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m.			

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	Nursing Progress Notes dated 6/10/15 at 7:00 p.m., indicated the resident was receiving oxygen at 10 liters per minute per nasal cannula. The resident had no appetite for supper. At 8:30 p.m., the resident indicated he could not breathe. He indicated if the Nurse could not do anything for him, then he wanted to go to the hospital. The Nurse checked the resident's oxygen saturation which was 95%. The resident was anxious and rapidly breathing. The Nurse then switched the oxygen concentrator to the oxygen tank "to appease" the resident. There was no documentation the Nurse offered a nebulizer treatment as ordered by the Physician. Nursing Progress Notes dated 6/11/15 at 1:00 a.m., indicated "Resident received in bed with complaints of difficulty breathing and disorientation/confusion. Writer assess oxygen saturation which was at 96%. Writer and Nurse Supervisor began to assess if resident was oriented to his new surroundings. Resident responds 'yes'. Resident continued to be anxious stating to turn up the oxygen concentrator, informed resident of concentrator being set at 10 liters per minute already. Called (Physician name) requesting one time Intramuscular (IM) shot of 1 mg of			

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	Ativan (an Antianxiety medication). MD gave verbal consent over the phone. IM shot of Ativan administered with 20 gauge needle in resident's right deltoid. Will check back on resident in 5 minutes." (sic) At 1:05 a.m., Nursing Progress Notes indicated the resident's oxygen saturation was 98% and the resident had calmed down, there was noticeable decrease in anxiety. Again there was no documentation of any nebulizer treatments administered to the resident for increased shortness of breath. Physician Orders dated 6/11/15 at 1:00 a.m. please give Lorazepam 1 mg IM times 1 dose now: diagnosis was anxiety. Nursing Progress Notes dated 6/11/15 at 9 a.m., indicated the resident had poor appetite. Nursing Progress Notes at 8:00 p.m., indicated appetite not present at this time, zero consumption of dinner at this time. Nursing Progress Notes dated 6/12/15 at 7:00 a.m., indicated the resident did not eat breakfast. Nursing Progress Notes dated 6/12/15 at 12:00 p.m., indicated the resident was only consuming occasional sips of fluid but refused lunch at this time. The dietary intake record for June 2015			

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	indicated the resident ate 10% for breakfast, lunch, and dinner on 6/10/15, however, the resident was not in the facility for breakfast and lunch on 6/10/15. The resident consumed 10% of breakfast and lunch on 6/11/15 and supper for that day was not completed. The resident consumed 0% for breakfast on 6/12/15 and lunch was not completed. Nursing Progress Notes dated 6/12/15 at 2:00 a.m., indicated the resident was verbally responsive to speech. The resident's respirations were labored but with no signs of respiratory distress. The resident's lung sounds were clear. Another progress note at 2:05 a.m., indicated the resident was observed with the oxygen nasal cannula in his mouth. After several attempts to educate the resident about the proper use of the nasal cannula, the resident still refused to remove it from his mouth. The Physician was notified and indicated that once he was in his office he would call a prescription for Ativan to the pharmacy and not to send the resident out to the hospital. There was no documentation the Nurse attempted to place an oxygen mask on the resident or offer a breathing treatment for increased shortness of breath. Nursing Progress Notes dated 6/12/15 at			

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	7:00 a.m., indicated the resident was observed with labored breathing with crackles noted to his lung sounds. The resident indicated "I do not feel like eating." An entry at 9:00 a.m., indicated the resident was taking occasional sips of water. An entry at 12:00 p.m., indicated the resident refused lunch and was still only taking occasional sips of water. There was no documentation the resident's Physician was notified of the significant change in condition and the loss of appetite. Nursing Progress Note dated 6/12/15 at 3:00 p.m., indicated the resident's family was visiting the resident. The family member indicated the resident was "knocked out." The family requested the Nurse send the resident out to the hospital immediately. The Nurse then called the ambulance service who arrived at the facility at 3:35 p.m. and the resident was taken to the emergency room. Review of Lab result drawn on 6/12/15 at 5:16 p.m., at the hospital indicated the BUN was 51 a high level (normal was 8-23) and the CR was .8 (.7-1.2) The Ambulance report dated 6/12/15 indicated "Dispatched to above location for complaint of patient in respiratory			

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	distress. Upon arrival found patient In bed with a nasal cannula giving him 0 2 at 10 LPM. Nurses on scene seem unaware that EMS has been contacted and no one is able to state a history of the current illness. Patient's brother is at bedside and he also denies calling EMS. Patient is in obvious respiratory distress and has fatigued respirations. Floor nurse and facility administrator were located and they state that the patient was admitted two days prior from Methodist Hospital. Patient has dx of lung cancer and pulmonary fibrosis with a DNR/DN1 signed. They state that patient refused breathing treatments, NRB therapy (as prescribed by his MD), and had stopped eating on arrival. Nurse states that patient has exhibited a steady decline since his arrival and states that the patient's brother wants him taken to the ED for IV fluid maintenance and a higher level of care. Patient's DNR is signed and a copy was brought to the ED with the patient. Patient was lifted to the cot and secured. Vitals taken, No veins noted in patient's arms suitable for venipuncture. Left EJ attempted with no success. Patient is nonverbal, unable to lift his limbs due to weakness, and has a vacant stare."(sic) Interview with the Interim Director of Nursing/Nurse Consultant on 9/17/15 at			

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	7:30 a.m., indicated the Ativan IM should not have been given without further nursing assessment on 6/11/15 on the midnight shift. She indicated there was a lack of treatment as far as the nebulizer treatments were not given as ordered every 4 hours by the Doctor as well as the PRN order had not been transcribed onto the MAR. The DoN indicated the nurse on duty during the midnight shift on 6/12/15 should have offered and/or provided an oxygen mask or tried to give the resident a breathing treatment. She indicated if a resident stated they wanted to go to the hospital, Nursing should send the resident to the hospital. She indicated the nurse on duty on 6/12/15 should have notified the DoN at some point before the ambulance had been called and/or the resident's POA for further guidance for the resident. This Federal Tag relates to Complaint IN00180655 3.1-37(a)			
F 0311 SS=D Bldg. 00	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.			

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	Based on observation, record review, and interview the the facility failed to ensure each resident received the necessary services to maintain personal hygiene related to providing assistance with showers for 1 of 3 residents reviewed for Activities of Daily Living (ADL's) of the 35 residents who met the criteria for ADL's. (Resident #52) Finding includes: On 9/14/15 at 8:53 a.m., Resident #52 was observed sitting in a wheelchair in his room. At that time, he was interviewed. The resident indicated he had not been given a shower for a couple of weeks. The record for Resident #52 was reviewed on 9/17/15 at 8:53 a.m. The resident's diagnoses included but were not limited to, chronic kidney disease stage 2, Insulin dependent diabetes mellitus, high blood pressure, anemia, hyperlipidemia, and stroke. The Quarterly Minimum Data Set (MDS) assessment dated 8/7/15 indicated the Brief Interview for Mental Status (BIMS) score was a 10, indicating the resident was moderately impaired for decision making. The resident needed physical help in the part of bathing activity with	F 0311	Format for plan of Correction F 311 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1.Resident # 52 has been interviewed and has requested showers be given early AM prior to dialysis twice a week. Schedule has been changed to accommodate resident's request. 2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken ; 1.All residentshave the potential risk to be affected by the same deficient practice. 2.All shower schedules have been reviewed and revised so that each resident isscheduled to have a shower at a minimum of twice a week. 3.Whatmeasures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur; 1.Nursing staff will be re-in serviced on the Shower policy and procedure 2.Shower Schedules will be reviewed and updated as needed 3.Current form reviewed and revised as needed 4.How the corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place ;	10/22/2015

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	one person physical assist. The resident had impairment with range of motion to both sides of his upper extremities. The current and updated plan of care dated 8/13/15 indicated the resident had an Activity of Daily Living (ADL) self care performance deficit related to hemiplegia. The skin and shower assessment for the month of July indicated the resident received a shower on 7/9 and a bed bath on 7/6/15. There were no other showers or bed baths documented for the rest of the month. The skin and shower assessment for the month of August 2015 indicated the resident received a shower on 8/3 and 8/9/15 and bed bath on 8/12/15. The skin and shower assessment for the month of September 2015 indicated the resident had not received a shower or a bed bath from 9/1-9/17/15. The shower schedule was reviewed. The resident's room number was listed for him to take a shower on Wednesday and Saturday it was unclear what time of the day he was to get the shower. Interview with CNA #3 on 9/17/15 at		1.Audit will be performed daily to ensure showers are being offered and given asscheduled. 2.This audit will be ongoing and DON/designee will be responsible for completing the audits 3.Results of Audit will be presented at QAPI meeting on going 5.Bywhat date the systemic changes will be completed October 22,2015 This Plan of Correction constitutes my written allegationof compliance for the deficiencies cited. However, submission of this Plan ofCorrection is not an admission that a deficiency exists or that one was citedcorrectly. This Plan of correction is submitted to meet requirementsestablished by state and federal law.	

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	9:54 a.m., indicated she had given the resident a shower some time last month. She indicated since the resident had dialysis everyday at the facility, the midnight shift gets him up early every morning. Interview with the MDS Coordinator on 9/17/15 at 9:56 a.m., indicated the shower schedule was unclear when the resident was to get his shower. She further indicated the resident had no showers in the month of September. The MDS Coordinator indicated the resident was alert and oriented and would let anyone know he had not had a shower. 3.1-38(a)(3)			
F 0312 SS=D Bldg. 00	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, record review and interview, the facility failed to ensure a shower was provided at least twice a week, to a resident who was dependent and required extensive to total assist with bathing for 1 of 3 residents reviewed for Activities of Daily Living (ADL's) of the 35 residents who met the criteria for	F 0312	Format for plan of Correction F 312 1.What corrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; 1.Resident # 71 shower scheduled has been reviewed and updated and showers will be given as scheduled.	10/22/2015

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	ADL's. (Resident #71) Finding includes: On 9/15/15 at 12:02 p.m., Resident #71 was observed sitting in a geri recliner chair in her room. At that time, the resident's son was interviewed. The son indicated he believed his mother only received a shower or bath once a week not twice a week, and preferred his mother received two showers a week. On 9/16/2015 at 8:22 a.m., Resident #71's record was reviewed. Diagnosis included, but were not limited to, hemiparesis, hypertension, expressive aphasia, anxiety, depression with depressed mood, vascular dementia, and cerebrovascular accident. The Minimum Data Set (MDS) assessment, dated 8/10/2015, indicated the resident had a Brief Interview for Mental Status (BIMS) of 99, indicating the MDS Coordinator was unable to assess cognition. The resident's functional status for bathing indicated total dependence with a two person physical assist with showers. The care plan, dated 9/1/2015, indicated, the resident required extensive to total assist by the staff with		2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken ; 1.All residents have the potential risk to be affected by the same deficient practice. 2.All shower schedules have been reviewed and revised so that each resident is scheduled to have a shower at a minimum of twice a week. 3.What measures will be put in place or what systemic changes will be made to ensurethat the deficient practice does not recur; 1.Nursingstaff will be re-in serviced on the Shower policy and procedure 2.Shower Schedules will be reviewed and updated as needed 3.Current for shower schedule and form has been reviewed and revised as needed 4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place ; 1.Audit will be performed daily to ensure showers are being offered and given asscheduled. 2.This audit will be ongoing and DON/designee will be responsible for completing the audits 3.Results of Audit will be presents at QAPI meeting B y what date thesystemic changes will be completed	

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	bathing/showering. The September 2015 shower sheet indicated there were only 4 showers documented as being given on September 1st, 3rd, 8th, and 15th. On 9/17/2015 at 8:47 a.m., CNA#3, indicated the resident was supposed to have showers three times a week, but her showers usually occurred on the evening shift. She further indicated sometimes the resident needed a shower on the day shift and she had given her one. After review of the September shower sheet, CNA #3 indicated the resident had not even received a shower two times a week. On 9/17/15 at 8:47 a.m., CNA#1, indicated the resident should have received showers two times a week on Tuesdays and Fridays. After review of the September shower sheet, CNA #1 indicated the resident dates did not indicate two times a week. 3.1-38(b)(2)		October 22,2015 This Plan of Correction constitutes my written allegationof compliance for the deficiencies cited. However, submission of this Plan ofCorrection is not an admission that a deficiency exists or that one was citedcorrectly. This Plan of correction is submitted to meet requirementsestablished by state and federal law.	
F 0315 SS=D Bldg. 00	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless			

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	the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review and interview, the facility failed to ensure signs and symptoms of a urinary tract infection were monitored for a resident with a foley catheter as well as ensure the indication for the use of the foley catheter for 2 of 2 residents reviewed for urinary catheter use of the 2 who met the criteria for urinary catheter use. (Residents #45 and #102) Findings include: 1. On 9/14/15 at 12:26 p.m., Resident #45 was observed in the Unit 4 dining room. A foley catheter drainage bag was observed and a urine odor was present. The record for Resident #45 was reviewed on 9/16/15 at 11:06 a.m. The resident's diagnosis included, but was not limited to, urinary retention. A Physician's order dated 8/13/15, indicated the resident was to have a urinalysis with a culture and sensitivity.	F 0315	Format for plan of Correction F 315 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1.Resident # 45 Resident was re-assessed and Dr.visited on 10/6/15 and found to be necessary. 2.Resident# 102 Resident had catheter removed on 9/17/2015 2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken ; 1.All current residents with Foley catheters have been re-assessed. 2.All residents with Foley catheters have a diagnosis for use of catheter, and orders for catheter care. 3.What measures will be put in place or what systemic changes will be made to ensurethat the deficient practice does not recur; 1.Nurses will be re-in-serviced on catheter policy and procedure. 2.Nurses will be re-in-serviced on documentation and monitoring of urinary tract	10/22/2015

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	Documentation in the Nursing progress notes dated 8/13/15 at 7:00 a.m., indicated the resident's urine was discolored. The Physician was notified and orders were received. At 7:30 (a.m. nor p.m. was specified) lab was in the facility to collect the urine specimen. At 11:50 (a.m. nor p.m. was specified) the Physician was notified of the urinalysis results and staff was awaiting a return call from the Physician for further orders. The next documented entry in the Nursing progress notes was on 8/17/15, four days later. There was no documentation of the resident's discolored urine and no documentation related to the Physician giving any further orders. The final urine culture result dated 8/14/15, indicated the resident's urine was positive for greater than 100,000 gram positive cocci. There was no documentation to indicate where the Physician was notified of the urine culture results. The plan of care dated 2/26/15, indicated the resident had an indwelling foley catheter due to the diagnosis of urinary retention and was at risk for urinary tract infections. The interventions included, but were not limited to, monitor foley for patency, signs and symptoms of		infections. 4.How the corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place ; 1.The 24hour report sheet will be audited daily for any changes in catheter care or new orders for catheter. 2.The 24hour sheet will be audited daily for urinary tract infections and review ofdocumentation. 3.This audit will be ongoing and DON/designee will be responsible for completing the audits 4.Results of audits will be reviewed at QAPI monthly meetings. 5.Bywhat date the systemic changes will be completed October 22,2015 This Plan of Correction constitutes my written allegationof compliance for the deficiencies cited. However, submission of this Plan ofCorrection is not an admission that a deficiency exists or that one was citedcorrectly. This Plan of correction is submitted to meet requirementsestablished by state and federal law.	

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	infection, pain and urinary status as well as notify Physician of significant change in resident's condition. Interview with the Interim DON/Nurse Consultant on 9/17/15 at 2:30 p.m., indicated the Physician should have been notified of the urine culture results and follow up documentation should have been completed related to the resident's discolored urine. 2. On 9/15/2015 at 9:18 a.m., Resident # 102 was observed in her room seated in a wheelchair. A Foley catheter was observed hanging from the bottom of the wheelchair in a dignity bag. On 9/15/2015 at 2:27 p.m., the resident was observed in her room seated in a wheelchair. Her catheter was observed hanging from the bottom of the wheelchair in a dignity bag, the tubing contained dark amber colored urine. On 9/16/2015 at 3:00 p.m., the resident was observed propelling herself down the hallway. Her catheter tubing hanging below the wheelchair contained dark and cloudy red tinged urine. On 9/17/2015 at 11:00 a.m., the resident was observed in her room seated in her wheelchair, her catheter tubing hanging below the wheelchair contained dark and			

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	cloudy red tinged urine with small red blood clots. On 9/17/2015 at 2:22 p.m., the resident was observed in room her room seated in her wheelchair. The catheter tubing hanging below the wheelchair contained clear yellow urine. The record for Resident #102 was reviewed on 9/16/2015 at 9:25 a.m. Her diagnoses included, but were not limited to, congestive heart failure, cardiovascular accident, and tardive dyskinesia. There was no documented diagnosis for the use of the Foley catheter. Review of the Physician's Orders indicated no orders related to daily Foley catheter care. Review of the Treatment Administration Record (TAR) indicated no documentation the staff had provided daily Foley catheter care. Interview with RN #2 on 9/18/2015 at 8:35 a.m., indicated she had worked on the unit for two days this week and had provided routine catheter care for the resident, review of the TAR with the nurse at the time indicated there was no order for Foley care or evidence to			

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	support the care had been provided. Interview with the Interim DoN/Nurse Consultant on 9/18/2015 at 8:45 a.m., indicated there was no admitting diagnosis for the Foley catheter and there should have been an order related to providing daily catheter care and documentation by the nursing staff to indicate daily catheter care had been provided every shift. 3.1-41(a)(1)			
F 0323 SS=J Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to thoroughly investigate an incident of choking to determine a root cause analysis as to where the resident was getting the food. The facility failed to ensure interventions were in place for the supervision for the resident who was on a mechanically altered diet, had a history of grabbing food off of other resident trays and had been sent out to the hospital for a choking episode. The facility failed to ensure the	F 0323	Plan of Correction 323 1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice: 1.Resident that was affected has been discharged from facility. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice: 1.All current residents medical records have been reviewed for diagnosis that might	10/22/2015

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	resident was supervised before and after meals resulting in another choking incident that led to the death of the resident for 1 of 3 residents reviewed for supervision. (Resident #56) In addition to the resident in immediate jeopardy, the facility failed to ensure food and/or snacks were removed from the resident's bedside table on the midnight shift resulting in the potential for harm that was not immediate jeopardy to 1 of 2 residents reviewed for supervision. (Resident #81) The immediate jeopardy began on 6/10/15 when there was no root cause analysis completed as to where the resident was getting the food from that led to another choking incident. The Administrator and the Interim Director of Nursing/Nurse Consultant were notified of the immediate jeopardy on 9/18/15 at 10:34 a.m. The immediate jeopardy was removed on 9/22/15 but noncompliance remained at the lower scope and severity level of no actual harm with potential for more than minimal harm that was not immediate jeopardy. Findings include: 1. The closed record review for Resident #56 was on 9/17/15 at 3:00 p.m. The resident's diagnoses included but were		place resident at risk for choking; 2.All current residents medical records have been review for dietary restrictions for thicken liquids, nectar liquids, and pureed diet. 3. All current residents who were identified as at risk from above criteria have been identified. 1.All identified residents' medical records, physician orders MDS and care plan have been reviewed to identify mobility status. 2.Of the resident reviewed only on resident can self- propel in wheelchair Based on this information Resident #81 is the only resident at risk due to the fact that he is mobile in his wheel chair. All other resident identified at risk are dependent on staff for transfer and mobility. 1.What measure will be put into place ,or systemic changes made, to ensure that the deficient practice will not recur, 1.A review of current investigative procedure has been reviewed and revised to ensure that investigation will be conducted to determine root cause of incident. 2.Procedure will conclude with an action plan to be documented when needed (Investigative procedure attached) 3.Department Heads or	

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	not limited to, Huntington's Chorea, acute agitation, vascular dementia with disturbance, depression, and anxiety. The Quarterly Minimum Data Set (MDS) assessment dated 4/10/15 indicated the resident was unable to complete the resident interview for cognition. The resident had long and short term memory problems. The resident was moderately impaired for decision making and could locate his room, knew staff faces, and knew he was in a nursing home. The resident was independent with no staff assist for locomotion on and off the unit and walking in the corridors. The resident needed supervision with set up help only for eating. The Annual MDS assessment dated 7/8/15 indicated the resident was unable to complete the resident interview for cognition. The resident had long and short term memory problems. The resident was moderately impaired for decision making and could locate his room, knew staff faces, and knew he was in a nursing home. The resident needed supervision with set up help only with locomotion on and off the unit and how the resident walked in the corridors. The resident was totally dependent with one person physical assist for eating.		designee will be responsible to initiate investigation and notify Administrator or designee within 24 hours. If incident is deemed a reportable Administrator to be notified immediately. Completion of investigation will be within5 days. 4.Are view of current tray pass procedure and return of trays was reviewed and revised (attached) 5. Resident #81 care plan was reviewed and revised and staff in-services regarding changes in plan of care. The in-service on change in plan of care was started on September 19, 2015 and is continuing until all have been in-serviced on changes. Monday 21, 2015 is completion date. 6.All department will receive in-services on the revised investigative procedure starting immediately and will be completed by Monday 21,2015 2.How will facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur 1.The charge nurse will be responsible to make round after one hour of meals to ensure that certified nursing assistants have remove meal trays from resident rooms and returned to kitchen. (monitoring tool attached) 2.It will be the responsibility of the department head to ensure that investigation are completed within time frames. It will be	

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	The care plan was reviewed. The problem updated 4/16/15 indicated the resident displayed signs of behaviors as evidenced by eating other resident's food or drinking their coffee. The Nursing interventions were to observe assess for hunger, thirst needs, and assess resident's understanding of the situation. Assess resident's coping skills and support system The June 2015 Physician recap indicated a pureed diet with whole milk and double portions every meal with thin liquids. The original date was 4/15/15. Nursing Progress Notes dated 6/6/15 at 1:00 a.m., indicated "Called to room by CNA. Resident observed choking, face/fingers turning blue. Resident unable to speak. Resident waving hands in air, oxygen saturation 62%. Immediately started Heimlich maneuver. Oxygen saturation up to 74%, pieces of sandwich started to come out of mouth. 911 immediately called. Resident continued to clench teeth and would not allow staff to take out rest of sandwich particles from mouth. Resident began to swallow sandwich particles causing resident to gasp for air, again oxygen saturation decreased to 68%. Began Heimlich maneuver again, more sandwich particles came out. Resident		responsibility of Administrator/or Designee maintain a log of initial investigative report and completion of report. 3.Administrator will be responsible to notify compliance corporate officer or designee of investigative incidents within 24 hours. This Plan of Correction constitutes my written allegationof compliance for the deficiencies cited. However, submission of this Plan ofCorrection is not an admission that a deficiency exists or that one was citedcorrectly. This Plan of correction is submitted to meet requirementsestablished by state and federal law.	

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	uncooperative with care due to diagnosis of Huntington's. Oxygen saturation up to 78%. Ambulance arrived, blood pressure 159/86, pulse 78, respirations 20, resident left via two attendants on stretcher, alert and responsive. Transferred to stretcher, stand/pivot times two attendants." Another entry in Nursing Progress Notes dated 6/8/15 at 3:00 p.m., indicated "Per medical records where entry mentions sandwich particles entry should have been written as food particles. After performing Heimlich for 10-12 minutes on resident, writer was exhausted and immediately after transfer began writing nurses notes to document entire event, during which the mistake of writing sandwich particles instead of food particles was made." Nursing Progress Notes dated 6/6/15 at 2:00 p.m., indicated the resident was admitted to the hospital with the diagnosis of aspiration pneumonia. Nursing Progress Notes dated 6/10/15 at 3:00 p.m., indicated the resident arrived back to facility from the hospital. Hospice was at the facility to admit the resident to their service. Physician Orders on readmit from the hospital dated 6/10/15 from the hospital			

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	indicated the resident's diet order was NPO (Nothing by mouth). Following Hospice admission, new Physician Order's dated 6/10/15 at 5:15 p.m., indicated "DC (Discontinue) all labs, Pureed diet with nectar thickened liquids, patient needs to be fed. Small bites only. Supervised only. Crush all meds finely and administer in applesauce." A new care plan dated 6/12/15 was initiated which indicated "High risk for aspiration. Eats food fast and in large amounts. Takes food off other resident's trays as well as dirty food carts." The Nursing interventions were "All staff will monitor resident while up and about and redirect as necessary to prevent him from taking food. Staff will feed resident all meals in small proportion and monitor closely for signs and symptoms of aspiration." Nursing Progress Notes dated 7/15/15 at 1:17 a.m., "Observed resident beginning to aspirate on Unit 3. Writer approached resident to assess resident condition, writer observed resident choking and skin color turning pale. Writer began administering Heimlich maneuver. Unit 4 Nurse entered situation monitoring pulse oximetry which was 65% at 1:20			

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	a.m. 911 called. Continued administering Heimlich maneuver. Intermittent suctioning began with moderate success. Resident began clenching jaws which prevented further suctioning. Oxygen saturation down to 62%. Second call placed to 911 on location of ambulance. Dispatch explained regular crew on another emergency, have to dispatch another crew. Heimlich maneuver continued with intermittent sweeping of mouth. Removed minor bits of food particles. Intermittent suctioning continued. EMT arrived at 1:35 a.m., and took control of situation and began intubation before transferring resident out of facility to ER." The Emergency room report dated 7/15/15 indicated "The patient was in cardiac arrest upon arrival with ventricular escape rhythm. CPR was in process. The patient did have return of spontaneous circulation prior to arrival. Patient was intubated in route and received no sedation or paralysis. He has had no purposeful movement since return of pulses. Reviewed Physician Order dated 7/15/15 at 5:15 a.m., indicated the resident had expired at the hospital.			

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	Interview with LPN #1 on 9/18/15 at 8:50 am indicated the resident did not really have behaviors he just ate really fast and needed to be supervised during meals because he also liked to take food off resident's meal trays. She indicated the resident was alert enough to know what was going on, he was also ambulatory. Interview with RN #1 the Director of Nursing (DoN) at the time of both choking incidents on 9/18/15 at 9:15 a.m. indicated the resident had Huntington's Chorea and wandered in and out of rooms. He also was observed many times to grab food and drink off of other resident's trays. She indicated after the choking incident on 6/6/15 there was a thorough investigation completed. She indicated the resident was found in his room on the floor. She believed the resident could have wandered into another resident's room and gotten a sandwich and ate it. She indicated the evening snacks were also left at the nurses station so she was not sure where the resident got the sandwich. The DoN knew it was not pureed food the resident had choked on. She indicated there was 1 nurse and 2 CNAS on Unit 3 where the resident resided working that night on the midnight shift. At the time of readmission, his diet order was changed			

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	to a pureed diet double portions with nectar thick liquids. The DoN indicated after the incident there was to be no food or drink left on the unit on all shifts. She indicated they kept the resident away from the main dining room and he was fed in his room by Nursing staff. She indicated after the resident came back he was a little weaker but still was looking for food and was still ambulatory. She indicated the resident was non verbal, did not speak and felt because of his Huntington's he did not always know what he was doing. The DoN indicated the resident was quick and was still able grab food off of trays and put it in his mouth before they could get to him. The DoN indicated there was a plan put into place. She had the Nurse Supervisor on 3-11 shift, to make sure he was not getting into any food left on resident trays. She indicated the 3-11 Nurse Supervisor had a checklist and would complete it and turn it into her every morning on how the meal trays were monitored and picked up after residents were through eating. She indicated there was also a Midnight Supervisor who also monitored the resident and if there was food left out. The DoN indicated the 11-7 Supervisor would give her a verbal report every morning. She also indicated the 3-11 Nurse Supervisor was not allowed to take a Unit or med cart for			

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	that very reason to monitor the residents and make sure left over meal trays were not left out and the food was taken back to the kitchen. The DoN indicated all of the written reports and the thorough investigation of the choking incident on 6/6/15 were unavailable for review. She indicated she had gone on vacation July 1-10 and when came back she was removed as the DoN and was moved to the in house dialysis. She did not know where any of the papers were or where any of the investigations were. She indicated the current Interim DoN was the DoN at the time of the second choking incident and she did not take part in any of that investigation. Interview with LPN #2 on 9/18/15 at 9:35 a.m., indicated he was the nurse taking care of the resident for both choking incidents. He indicated the resident had Huntington's disease and got up frequently at night sometimes more than 20 times a night. LPN #2 indicated the resident was independent for transfers and walked independently as well, however the staff tried to keep him on the unit before he got out of his room. He indicated the resident had a delayed thought process and would stop in the middle of doing things. LPN #2 indicated the first choking incident happened around 1:00 a.m. He indicated			

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	the resident got a hold of a sandwich of some sort, because the food that came out of his mouth was not pureed. He indicated he initiated the Heimlich on him and was able to remove the food, 911 was called and he left. The LPN indicated the resident was alert and responsive after the first choking incident. He indicated when the resident came back he was aware of his new diet of pureed food with double portions and thickened liquids and the resident had to be now supervised during meals at all times. The LPN indicated he frequently made rounds up and down the hall during his shift to check on the whereabouts of the resident. He indicated on 7/15/15 before the resident had choked another resident had asked him to assess her and take her vital signs. So he went into the resident's room. LPN #2 indicated the two CNAS assigned to the unit were in other resident rooms doing rounds. The LPN indicated after he was finished with the other resident, he left the room and returned to the nurses station to do charting. Shortly thereafter, he heard someone say "Hey" and at that time, he saw Resident #56 fall to the floor. He indicated the resident was in the intersection of unit 3 and the hallway coming from unit 4. The LPN indicated at that time he called for help and the nurse from unit 4 came down and helped			

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	him. 911 was called and he initiated the Heimlich maneuver. He indicated the resident was unresponsive at that time. LPN #2 indicated he had removed food particles from his mouth not pureed food. He indicated as soon as 911 got there, they took over and intubated the resident. The resident was still unresponsive when he was transferred out of the facility. He indicated later that night, he had found out the resident had taken food off a tray that was left out on unit 4. The LPN indicated there was no midnight supervisor working on 7/15/15. Interview with the Interim DoN who was the Nurse Consultant on 9/18/15 10:00 a.m., indicated there was no written investigation documented or available for review after the resident choked on 6/6/15. She indicated when the Midnight Supervisor was terminated, the investigations with documentation of interviews, witnesses, and interventions disappeared and were nowhere to be found. She further indicated she did not start at the facility until 8/15/15. Interview with the Administrator on 9/18/15 at 10:30 a.m., indicated RN #1 was the DoN at the time of both choking incidents. He indicated there was no 3-11 Supervisor in the facility in June or July 2015. He indicated the Nurse, RN			

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	#1 was referring to was just another Nurse, not the Supervisor. He had indicated he had thought the DoN had taken care of the investigation and the plan of action to supervise the resident. 2. On 9/21/15 at 4:15 a.m., in room 410 bed one, the resident was observed in bed with his eyes closed. At that time, there was half of a hamburger sandwich on his over bed table. The room door was open. Continued observation at that time, Resident #81 who also resided in the room was observed in bed with his head under the blanket. Further observation of Resident #81's over bed table, there was an empty juice container, a package of opened cookies and one chocolate candy bar. Interview with LPN #3 the Unit 4 Nurse on 9/21/15 at 4:20 a.m., indicated the resident in 410 bed one happened to be up at the time she came on her shift. She indicated the hamburger sandwich was left over from supper and the resident indicated he still wanted to eat it. LPN #3 indicated Resident #81 who also resided in the same room was on some type of aspiration precautions. She indicated staff were supposed to supervise Resident #81 while he ate. She indicated Resident #81 was up around 2:30 a.m., to use the bathroom and was			

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	asked if he still wanted his cookies and he indicated yes, he still wanted them. On 9/21/15 at 4:17 a.m., in room 306 bed one the resident was observed in bed with his eyes closed. There was a package of graham crackers observed on the over bed table. Interview with the LPN #4 at that time, indicated the graham crackers should not have been on the resident's over bed table. The record for Resident #81 was reviewed 9/21/15 at 6:45 a.m. The resident's diagnoses included, but were not limited to difficulty swallowing, aspiration into respiratory tract, narrowing of the esophagus, confusion, and cognitive impairment. Physician Orders dated 9/6/15, indicated the resident was to receive a mechanical soft diet with nectar thick liquids. The Quarterly Minimum Data Set (MDS) assessment dated 6/18/15 indicated the resident's Brief Interview for Mental Status (BIMS) score was a 6 indicating he was not alert and oriented. The resident needed limited assistance with one person physical assist with walking in the corridor and walking in the room.			

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	The resident needed supervision with set up help only with locomotion on and off the unit. The resident was on a mechanically altered diet. The current plan of care dated 9/18/15 indicated "The resident has a swallowing problem related to difficulty with thin liquids is on thicken liquids." The Nursing approaches were to follow the prescribed diet. Instruct resident to eat in an upright position, to eat slowly, observe/document and report as needed for any signs or symptoms of dysphagia (difficulty swallowing), pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat, or concerns that appear during meals, and to chew each bit thoroughly. Interview with the Interim Director of Nursing (DoN)/Nurse Consultant on 9/21/15 at 6:30 a.m., indicated the hamburger sandwich should not have been left on the resident's over bed table. She further indicated the cookies and candy bar should not have been left on Resident #81's over bed table. She further indicated LPN #3 and LPN #4 had been inserviced on the system for tray pick up and snack distribution. The Immediate Jeopardy that began on			

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	6/10/15 was removed on 9/22/15 when the facility had ensured Nursing staff were thoroughly inserviced on the new tray removal and snack distribution protocol. The facility also identified residents who were at risk for choking and aspiration and inserviced staff on precautions to prevent any accidents. The facility also put a system and new policy in place to investigate and determine the root cause analysis of all incidents, but non compliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy because observation on 9/21/15 at 4:17 a.m., there were still residents with food on their over bed tables that could be seen from the hallway. 3.1-45(a)(2)			
F 0325 SS=D Bldg. 00	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical			

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	condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, record review and interview, the facility failed to ensure the Registered Dietitian's (RD) recommendations were acted upon in a timely manner for 1 of 1 residents reviewed for dialysis. (Resident #52) Finding includes: On 9/17/15 at 8:52 a.m., Resident #52 was observed lying in bed. At that time, there were two nurses in his room performing hemodialysis. The record for Resident #52 was reviewed on 9/17/15 at 8:53 a.m. The resident's diagnoses included but were not limited to, chronic kidney disease stage 2, Insulin dependent diabetes mellitus, high blood pressure, anemia, hyperlipidemia, and stroke. The Quarterly Minimum Data Set (MDS) assessment dated 8/7/15 indicated the Brief Interview for Mental Status (BIMS) score was a 10, indicating the resident was moderately impaired for decision making. The resident weighed 197 pounds and no history of weight loss. The resident was receiving a therapeutic diet and received hemodialysis.	F 0325	Format for plan of Correction F 325 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1.Resident# 52 Renal Dietician orders have been addressed and resident is receiving dietas ordered. 2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken ; 1.All resident on renal dialysis medical records have been reviewed and all are receiving diets recommended by dietician and or physician. 3.What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur; 1.Policies will be reviewed and revised if needed 2.Nurses will be re-in-serviced on policy for following renal dietician recommendationstimely. 4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place ; 1.Any new renal dietician orders will be placed on 24 hour report sheet.	10/22/2015

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	Physician Orders on the 9/2015 recap indicated the resident was to receive a renal diet with no tomatoes and potatoes. The resident was on a fluid restriction and was to receive Prostat (a protein supplement) 30 cubic centimeters (cc) twice a day. A RD Progress Note dated 8/26/15 indicated the report by the renal RD was reviewed and the resident had met his goals for all labs. The RD indicated the resident received a mechanical soft diet and 30 cc Prostat supplement. A fax from the hemodialysis RD dated 9/11/15 indicated to please add double portions of meat and egg at breakfast and double portions of meat at lunch and dinner. The RD recommended to add Nepro (a renal nutritional supplement) twice a day and to change the morning administration of Renvela (a medication used to decrease Phosphorus levels) from 7:00 a.m. to 6:30 a.m. to match early meal tray. The rationale by the RD for the recommendation was the wound continued to be slow healing and the patient requests extra trays of food. The recommendation was not signed by the Physician until 9/15/15 (4 days after the recommendation).		2.24 hour report sheet will be audited daily and this will be ongoing DON/designee will be responsible for completing the audits. 3.Results of audits will be reviewed at QAPI monthly meetings. B y what date thesystemic changes will be completed October 22,2015 This Plan of Correction constitutes my written allegationof compliance for the deficiencies cited. However, submission of this Plan ofCorrection is not an admission that a deficiency exists or that one was citedcorrectly. This Plan of correction is submitted to meet requirementsestablished by state and federal law.	

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	The Medication Administration Record MAR) for the month of 9/2015 indicated the Renvela was signed out as being administered at 7:00 a.m. from 9/11-9/17/15. Physician Orders dated 9/11-9/17/15 indicated there was no order for the Nepro supplement. Interview with the Interim Director of Nursing (DoN) on 9/17/15 at 2:22 p.m., indicated RN #2 one of the hemodialysis nurses indicated the recommendations were handed to her yesterday and she was working on getting them in place today. The DoN indicated the RD recommendations should have been acted upon within 48 hours of the date they were written. She indicated there was no policy for this but this was her expectation. 3.1-46(a)(1)			
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate			

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	monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure a gradual dose reduction was attempted related to antidepressants and antianxiety medications for 1 of 5 residents reviewed for unnecessary medications. (Resident #55) Finding includes: The record for Resident #55 was reviewed on 9/16/15 at 9:10 a.m. The resident's diagnoses included, but were not limited to, mood disturbance, depression and atypical psychosis. The September 2015 Physician's order summary (POS), indicated the resident was receiving Clonazepam (an	F 0329	Plan of Correction F 329 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1.Resident# 55 GDR was reviewed by Pharmacist at September review and recommendation was presented to physician. , 2. Vanguard (Psychiatric consultant) monthly reviews have been documented. 2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken ; 1. All residents on psychiatric medication havebeen reviewed by Pharmacist for GDR on September 24, 2015. Pharmacy recommendation have been addressed by physicians	10/22/2015

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	antianxiety medication) 0.5 milligrams (mg) daily. The original order was dated 6/24/14. The resident was also receiving Clonazepam 1 mg every evening. The original order was dated 6/30/14. A Physician's order dated 1/13/15 indicated the resident was receiving Paxil (an antidepressant) 30 mg daily and Remeron (an antidepressant) 30 mg at bedtime (hs). A Pharmacy recommendation dated 6/18/15, indicated the following: "Resident is currently on Remeron 30 mg hs, Paxil 30 mg daily and Klonopin 0.5 mg every morning and 1 mg every evening. Psychotropic dose reduction evaluation is due. Please evaluate if the current dose is in accordance with current standards of treatment. The comments below may assist you in the documentation process. Please check the appropriate response and add additional information as requested. The Physician checked the box which indicated the resident's "Condition is not well controlled/stable and a reduction is likely to impair the resident's function and/or cause psychiatric instability." If this box was checked, patient specific information was to be documented. There was no additional documentation on the Pharmacy recommendation sheet as to		2.Pharmacist will be conducting GDR monthly and has a return visit scheduled for October 14,2015. 3.What measures will be put in place or what systemic changes will be made to ensurethat the deficient practice does not recur; 1.Pharmacist will prepare a GDR report monthly after he has reviewed residents' medicalrecord. 2.A meeting was held to discuss with physicians the importance of documenting reason for declining to attempt GDR. 4.How the corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place ; 1.Pharmacist will provide monthly report that indicates GDR review and recommendations 2.DON/Designee will review recommendations monthly to ensure that recommendations have beenaddressed within 30 days. This will be ongoing. Monthly pharmacy review and thedoctors' recommendations. 3.Results of audits will be presented at QAPI monthly meetings. By what date thesystemic changes will be completed October 22,2015 This Plan of Correction constitutes my written allegationof compliance for the deficiencies cited. However, submission of this Plan of	

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	why the medications could not be reduced." The Annual Minimum Data Set (MDS) assessment dated 6/23/15, indicated the resident had no recent behavior issues. There was no documentation in the Nursing progress notes from July-September 2015 as well as the Social Service progress notes from July-September 2015 related to resident behaviors. The resident was not being monitored in the Behavior Management program. Interview with the Interim DON/Nurse Consultant on 9/17/15 at 2:00 p.m., indicated there was no specific documentation related to why the Physician refused the psychotropic medication evaluation in June 2015. 3.1-48(b)(2)		Correction is not an admission that a deficiency exists or that one was citedcorrectly. This Plan of correction is submitted to meet requirementsestablished by state and federal law.	
F 0371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review and	F 0371	Plan of Correction F 371 1.	10/22/2015

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	interview, the facility failed to ensure food was stored and prepared under sanitary conditions related to food being served below normal safety temperature ranges and dented cans stored on the shelves in the dry storage room. (The Main Kitchen) Findings included: 1. On 9/18/2015 at 12:15 p.m., the final Kitchen tour with Dietary Cook #1 indicated the following was observed: Observation of the steam table with Dietary Cook #1 indicated the cook was observed taking the temperature of the lunch meal. The lunch meal included, but was not limited to, breaded baked fish, spinach, hot dogs and cold pasta. The spinach was 100 degrees Fahrenheit, the breaded baked fish was 100 degrees Fahrenheit, the hot dogs were also 100 degrees Fahrenheit. The Cook did not temp the cold pasta. Interview at that time with Dietary Cook #1 indicated she had previously taken the food temperatures prior to the observation. The temperature logs were then requested. There was no documentation of the food temps in the log book. Continued interview with the Cook indicated she had taken the food		What corrective action(s) will be accomplished for thoseresidents found to have been affected by the deficient practice; a. In-service staff on the proper procedure of checking thetemperature prior to each meal and document the results in the log book. b. In-service staff on procedure of removing dented cansfrom shelves and return to vendor. 2. How other residents having the potential to be affected by thesame deficient practice will be identified and what corrective action(s) willbe taken; a. In-service staff on the proper procedure of checking thetemperature prior to each meal and document the results in the log book. b. In-service staff on procedure of removing dented cansfrom shelves and return to vendor. 3. What measures will be put in place or what systemic changeswill be made to ensure that the deficient practice does not recur; a. Dietary manager will check and initial the log book dailyand randomly check temps each meal once a week to verify temps are correct. b. Specify a specific location to put all dented cans to bereturned to vendor. 4. How the corrective action(s) will be monitored to ensure thedeficient practice will not recur, i.e., what quality assurance program will beput into place; a. Results of audit will be reviewed at QAPI monthlymeetings for 6 months. b. Results of audit will	

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	temps and did not document them in the log book or on a separate piece of paper and she could not recall the temperatures she had taken. Interview with the Dietary Manager on 9/18/2015 at 1:00 p.m., indicated the cook had not temped the food prior to the observation. He also indicated all meals should be temped prior each meal and documented into the log book. A regular diet test tray was ordered and temped at 1:11 p.m., the cold pasta was 77 degrees Fahrenheit, the spinach was 102 degrees Fahrenheit and the breaded baked fish was 111.5 degrees Fahrenheit. Review of the current Food Temperature Chart dated 3/06 provided by the Dietary Food Manager, indicated hot entrees desired temperatures were to range from 140-165 degrees Fahrenheit. "Preferred temps to maintain proper temperatures for meal service: Hot-165 degrees Fahrenheit and Cold-35 degrees." The Dietary Food Manager indicated at that time, the cooks were to record the temperatures of food on the temperature chart. 2. During the initial brief tour of the kitchen with the Dietary Manager (DM) on 9/14/2015 at 8:15 a.m., the dry food		be reviewed at QAPI monthlymeetings for 6 months. 5. By what date the systemic changes will be completedOctober 22, 2015. This Plan of Correction constitutes my written allegationof compliance for the deficiencies cited. However, submission of this Plan ofCorrection is not an admission that a deficiency exists or that one was citedcorrectly. This Plan of correction is submitted to meet requirementsestablished by state and federal law.	

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	storage room was observed. There were (9) food cans observed stored on the shelves with dents: -three cans of refried beans -one can of great northern beans -one can of kidney beans -one can of purple plum halves -one can of whole corn -one can of pineapples -one can of stewed tomatoes Interview at the time with the DM indicated the above listed dented cans should have been taken off the shelves and stored separately until they were returned and credited back to the facility. 3.1-21(a)(2)			
F 0406 SS=D Bldg. 00	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part)			

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	from a provider of specialized rehabilitative services. Based on record review and interview, the facility failed to provide specialized rehabilitative services as determined by the comprehensive assessment related to not providing yearly resident reviews for 1 of 1 resident reviewed for Preadmission Assessment Screening services (PASRR). (Resident # 38) Finding includes: The record for Resident #38 was reviewed on 9/16/2015 at 11:27 a.m. The resident's diagnoses included, but were not limited to, diabetes, dialysis, schizophrenia, anxiety, pseudulbar affect, dementia with behavior disturbance, and brain injury with disinhabition. The Level ll: PASRR/MI Mental Health Assessment dated 12/20/2011 indicated, the resident was determined to be mentally ill. His Level ll diagnoses included, Schizophrenia and Anxiety. The resident's services of less intensity than specialized services included, but were not limited to, Yearly Resident Reviews. There were no additional yearly reviews in the resident's record. Interview with the Social Service Director on 9/16/2015 at 1:42 p.m., indicated there had been no annual	F 0406	Format for plan of Correction F 406 1.What corrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; 1.Resident# 38: Was seen by the Edgewater healthsystem group on October 7, 2015 2.How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken ; 1.All Level 2 resident charts were reviewed to assess if specialized services had been received per policy. If needed, appointments have been scheduled to becompleted by October 22,2015 3.What measures will be put in place or what systemic changes will be made to ensurethat the deficient practice does not recur; 1.Policy was reviewed and placed in specialized service book 2.A tickler file has been developed to track when next visit will need to bescheduled for all relevant residents. 4.How the corrective action(s) will be monitored to ensure the deficient practicewill not recur, i.e., what quality assurance program will be put into place ; 1.Monthly reviews of residents requiring specialized services will be conducted by	10/22/2015

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	resident reviews completed for the resident as indicated on the Level ll form related to the resident's Significant Change in Condition Assessment completed in 2011. 3.1-23(a)		socialservices .This will be ongoing. Social Services will be responsible for completing the audits 2.Results of level II assessments will be reviewed at QAPI monthly meetings By what date thesystemic changes will be completed October 22,2015 This Plan of Correction constitutes my written allegationof compliance for the deficiencies cited. However, submission of this Plan ofCorrection is not an admission that a deficiency exists or that one was citedcorrectly. This Plan of correction is submitted to meet requirementsestablished by state and federal law.	
F 0441 SS=E Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.			

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	(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review and interview, the facility failed to ensure urinals, wash basins and seat risers were stored correctly. The facility also failed to ensure hand hygiene was completed after glove removal and linens were handled correctly for 1 of 1 residents observed during dialysis and on 2 of 3 units throughout the facility. (Resident #52 and Units 3 and 5) Findings include: 1. On 9/14/15 at 1:55 p.m., a toilet seat riser was observed on the floor next to the toilet in Room 509. Dried feces was also observed on the seat riser. On 9/15/15 at 9:49 a.m., the toilet seat	F 0441	Format for plan of Correction F 441 1.What corrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; 1.Resident# 52: The nurse was re-educated to handwashing policy and procedure immediatelyafter observation. 2.How other residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken ; 1.All residents have the potential to be affected by the same deficient practice. Allstaff will be re-in-service on hand washing and infection control policies 3.What measures will be put in place or what systemic changes	10/22/2015

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	riser was again observed on the floor. Two residents resided in this room. 2. On 09/16/15 at 8:46 a.m., a urinal was observed under the bed in Room 505. There were also three bath basins on the floor uncovered and a plastic toilet riser was observed on the floor by the toilet and it was noted to be dirty. Two residents resided in this room. 3. On 9/16/15 at 8:05 a.m. LPN #6 was observed preparing Resident #52 for Home Hemodialysis (Hemodialysis performed at the facility). At that time, the LPN was observed to wash her hands with soap and water and donned a pair of gloves to both of her hands. The LPN proceeded with setting up the Hemodialysis machine, connecting tubing and inserting the blood filter into the machine. After preparing the machine, the LPN was ready to access the resident's fistula. The LPN washed her hands with soap and water and donned a pair of gloves to both of her hands. She placed a pressure packet on the resident's bed. Inside the packet there was a face shield, syringes and needles. She then draped the resident's underside of his right arm. She tied the tourniquet around the resident's arm. She removed her gloves and donned clean gloves. At that time, she did not use alcohol gel or wash her hands with soap and water. The LPN		will be made to ensure that the deficient practice does not recur; 1.HandwashingPolicy in-service has be presented to all staff and will be followed by skill observation 2.LinenHandling policy will be been re-in serviced. 3.Cleaning and storing of urinals, wash basins and seat risers policy will be re-inserviced. 4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place ; 1.Audits will be conducted daily for 2 months, twice a week for next 2 months and monthlyfor the next 2 months. 2.Hand washing skills will be observed and documented on nursing staff annually. DON/designee will be responsible for completing the audits 3.Audit outcomes will be reviewed at QAPI meetings for 6 months. 5.Bywhat date the systemic changes will be completed October 22,2015 This Plan of Correction constitutes my written allegationof compliance for the deficiencies cited. However, submission of this Plan ofCorrection is not an admission that a deficiency exists or that one was citedcorrectly. This Plan of correction is submitted to meet requirementsestablished by state	

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	removed the cap of the needle and accessed the arterial line first. After getting a blood return, she removed her gloves and donned clean gloves. She did not use alcohol gel or wash her hands with soap and water. She removed another needle from the wrapper and accessed the venous port. After getting a blood return, she used the cut pieces of tape and secured both needles and removed her gloves and donned clean gloves. Again there was no use of alcohol gel or washing her hands with soap and water. She connected both arterial and venous lines to the three way tubing and started the Hemodialysis machine. After the procedure of connecting the resident, she removed her gloves and washed her hands with soap and water. Interview with RN Case Manager from the Hemodialysis Center on 9/16/15 at 11:00 a.m., indicated she enforced good hand washing and the use of changing gloves. She indicated it was her expectations for the nurses to wash their hands with soap and water or use alcohol gel before donning gloves and at glove removal. Interview with the Interim DoN/Nurse Consultant at that time indicated the nurse should have washed her hands with		and federal law.	

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	soap and water or used an alcohol based gel after removing her gloves and before donning a new pair. The current 2015 Infection Control Guidelines from the Hemodialysis policy book provided the the Interim DoN/Nurse Consultant indicated "Change gloves and practice hand hygiene between each patient and/or station and after touching biohazard containers to prevent cross contamination. If gloves are visibly contaminated, change gloves and cleanse hands before touching surfaces and before performing other activities. Interview with LPN #6 on 9/16/15 at 1:00 p.m., indicated she was aware she did not wash her hands with soap and water or use alcohol gel after glove removal and before donning another pair of gloves. 4. On 9/17/2015 at 9:45 a.m., Housekeeping Manager was observed on Unit 3, folding sheets from the hall linen cart. The sheets were in contact with his uniform and up against his body. On 9/17/2015 at 9:48 a.m., CNA #4 was observed holding linen up against her body, in contact with her uniform, and entering a residents room.			

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	Interview with the Housekeeping Manager on 9/17/2015 at 10:04 a.m., indicated the staff were not suppose to place linen up against their body because that was an infection control issue. 3.1-18(b)(1) 3.1-19(g)			
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain a functional and sanitary environment related to urine odors, marred doors and walls, stained and peeling ceiling tiles, dirty floor tile, marred bedside stands and over bed tables, marred and paint chipped heat registers, food and beverage spillage on walls, missing floor tile, dirty and dusty pipes and ceiling vents, accumulation of food debris along baseboard, and leaking dish machine in 1 of 1 kitchens and on 3 of 3 units throughout the facility. (The Main Kitchen, Units 3, 4, and 5) Findings include:	F 0465	Plan of Correction F 465 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1.Facility will maintain a safe, functional, and sanitary environment. The issues that were cited have been corrected. The facility will audit areas cited at least weekly to ensure continued compliance.Staff will be in-serviced on the need to keep all areas in safe, functional, andsanitary condition. 2.How other residents having the potential to be affected by the same deficient practice will be identified and what correctiveaction(s) will be taken ; 1.All areas not cited will be checked to ensurethat they also	10/22/2015

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	1. During the Environmental Tour on 9/17/15 at 10:50 a.m., with the Maintenance Supervisor, the following was observed: Unit 3 a. A strong urine odor was noted in Room 304. The urine odor was stronger in the bathroom. Three residents resided in this room. b. There was a dried substance on the wall and behind the head of the bed for beds A and B in Room 305. The base of the heat register was also scratched and marred. Two residents resided in this room. c. The ceiling tile above bed C in Room 306 was stained. Two residents resided in this room. d. The door frame to Room 307 as well as the bathroom door frame was scratched and marred. The bathroom floor tile was also discolored. Two residents resided in this room. e. The bathroom floor tile was discolored and cracked in sections in Room 308. The bathroom door was scratched and marred and the toilet seat was discolored and peeling in sections. One resident		are in full compliance being safe, functional, and sanitary. 3.What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur; 1. An audit tool has been established to ensure continued compliance with weeklyaudits. Audits will be conducted by the Maintenance Manager and DietaryManager. 4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place ; 1.Report of audits will be presented to QAPImonthly meeting. 5.By what date the systemic changes will becompleted October 22,2015 This Plan of Correction constitutes my written allegationof compliance for the deficiencies cited. However, submission of this Plan ofCorrection is not an admission that a deficiency exists or that one was citedcorrectly. This Plan of correction is submitted to meet requirementsestablished by state and federal law.	

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	resided in this room. f. The bathroom floor tile in Room 310 was discolored. The non-skid strips on the bathroom floor were peeling and lifting up in sections. The door frame was scratched and marred. Two residents resided in this room. Unit 4 a. The bedside stand for bed B in Room 401, was scratched and marred. The base of the heat register was also scratched and marred. The bathroom floor tile was discolored as well as the grout. Two residents resided in this room. b. The bathroom door frame was paint chipped and marred in Room 402. The bathroom floor tile was discolored as well as the grout. The floor mat located next to bed C was torn in sections. The base of the over bed table for bed C was also paint chipped and marred. Three residents resided in this room. c. The bathroom floor tile as well as the grout was discolored in Room 403. The wall behind the head of bed B was scratched and marred. The base of the bathroom door was scratched and marred. Three residents resided in this room.			

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	d. The bathroom door frame was paint chipped and marred in Room 404. The bathroom floor tile as well as the grout were discolored. There was a residue on the bathroom floor where non-skid strips used to be. The walls behind the heads of beds A and B were scratched and marred. The closet doors were paint chipped and marred as well as the base of the heat register. Three residents resided in this room. e. The wall next to bed B in Room 407 was scratched and marred as well as the bed side stand. The bathroom floor tile was discolored and the ceiling tile above the toilet was peeling around the edges. The faucet drain in the tub was loose and detached from the tub. Two residents resided in this room. f. The wall behind the head of bed B in Room 412 was scratched and marred. The door to the room was scratched and marred. The floor tile behind the door was warped and lifting in sections. Two residents resided in this room. Unit 5 a. The wall behind the head of bed B in Room 501 was marred and gouged. The base of the heat register was rusted in sections. The wall above and below the			

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	sink in the bathroom was paint chipped. There was an accumulation of dead insects in the bathroom light fixture. The inside of the toilet bowl had a rust build up. Two residents resided in this room. b. The wall behind bed B in Room 503 was paint chipped and marred. The base of the over bed table is rusted. The wall above and below the sink in the bathroom was paint chipped. There was an accumulation of dead insects in the bathroom light fixture. The inside of the toilet bowl had a rust build up. One resident resided in this room. c. The wall behind bed B in Room 505 was marred. There was no pull string for the over bed light. The filter was coming out of the bottom of the floor register. The floor register was marred and rusty. The bathroom door was gouged and missing molding. Two residents resided in this room. d. The wheelchair arm rests were torn and the wheelchair was dirty for the resident who resided in bed A in Room 506. The bathroom walls were marred and scuffed. There were rusted bolts on the side of the toilet. Two residents resided in this room. e. The bathroom door was paint chipped			

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	and marred in Room 509. Two residents resided in this room. f. The wall next to bed A in Room 511 was marred. Two residents resided in this room. g. The heat register was rusted at the base in Room 512. Two residents resided in this room. Interview with the Maintenance Supervisor at the time, indicated all of the above areas were in need of cleaning and/or repair. 2. During the brief initial tour of the kitchen with the Dietary Manager (DM) on 9/14/2015 at 8:30 a.m., the following was observed: a. There was a dried white substance along the red brick tile in the dish washing are. b. The cove base under the dishwasher was peeling from the wall. c. There were multiple missing floor tiles near the the 3 compartment sink. d. The piping along the middle of the wall behind the stove had an accumulation of dirt and dust.			

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	e. There was an accumulation of dirt, food, and dried food substances along the coves bases along the walls of the entire kitchen. f. There was a brown dried substance along the wall near the servery. g. There was an accumulation of dust and dried food substances on the top of the two outlets on along the wall near the servery. h. There were four ceiling tiles in the dry storage room that were peeling. i. There was a dried brown substance along the white brick wall next to the juice machine. j. There was an accumulation of dirt and dried food substances along the wall of the 3 compartment sink. k. There was a dried white substance along the floor underneath the 3 compartment sink. l. There was an accumulation of dust in the vent in the front/bottom of the refrigerator. Interview at the time with the DM indicated all the above was in need of			

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	cleaning and or repair. 3.1-21(i)(2)			
F 0490 SS=D Bldg. 00	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interview the facility failed to ensure measures were in place for the facility to be administered efficiently and effectively to attain the highest practicable well- being of the resident related to thoroughly investigate an incident of choking to determine a root cause analysis as to where the resident was getting the food from. (Resident #56) Findings include: 1. The closed record review for Resident #56 was on 9/17/15 at 3:00 p.m. The resident's diagnoses included but were not limited to, Huntington's Chorea, acute agitation, vascular dementia with disturbance, depression, and anxiety. The Quarterly Minimum Data Set (MDS)	F 0490	Format for plan of Correction F 490 1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; 1.Resident# 56 is no longer in the facility. 2.How other residents having the potential to be affected by the same deficientpractice will be identified and what corrective action(s) will be taken ; 1.All current residents have the potential to be effected by the same deficient practice. 3.What measures will be put in place or what systemic changes will be made to ensurethat the deficient practice does not recur; 1.Areview of the current investigative procedure has been reviewed and revised toensure that the investigation will be conducted to determine the root cause analysis.	10/22/2015

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	assessment dated 4/10/15 indicated the resident was unable to complete the resident interview for cognition. The resident had long and short term memory problems. The resident was moderately impaired for decision making and could locate his room, knew staff faces, and knew he was in a nursing home. The resident was independent with no staff assist for locomotion on and off the unit and walking in the corridors. The resident needed supervision with set up help only for eating. The Annual MDS assessment dated 7/8/15 indicated the resident was unable to complete the resident interview for cognition. The resident had long and short term memory problems. The resident was moderately impaired for decision making and could locate his room, knew staff faces, and knew he was in a nursing home. The resident needed supervision with set up help only with locomotion on and off the unit and how the resident walked in the corridors. The resident was totally dependent with one person physical assist for eating. The care plan was reviewed. The problem updated 4/16/15 indicated the resident displayed signs of behaviors as evidenced by eating other resident's food or drinking their coffee. The Nursing		2.Procedure will conclude with an action plan to document root cause of incident. 3.Department Heads or designee will be responsible to initiate investigation and notify Administrator or designee within 24 hours. If incident is deemed a reportable theAdministrator is to be notified immediately. Completion of investigation willbe within 5 days. 4.All department heads will be in-serviced on the revised investigative procedure. 4.How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place ; 1.It will be the responsibility of the department head to ensure that the investigation is completed within the required time frames. It will be the responsibility of the Administrator/ or Designee to maintain a log of initial investigative report and completion of report. 2.Administratorwill be responsible to notify the Compliance Corporate Officer or designee ofall investigative incidents within 24hours. 3.The investigative log will be reviewed at the QAPI meeting on going. 5.By what date the systemic changes will be completed October 22,2015 This Plan of Correction constitutes my written allegationof	

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	interventions were to observe assess for hunger, thirst needs, and assess resident's understanding of the situation. Assess resident's coping skills and support system The June 2015 Physician recap indicated a pureed diet with whole milk and double portions every meal with thin liquids. The original date was 4/15/15. Nursing Progress Notes dated 6/6/15 at 1:00 a.m., indicated "Called to room by CNA. Resident observed choking, face/fingers turning blue. Resident unable to speak. Resident waving hands in air, oxygen saturation 62%. Immediately started Heimlich maneuver. Oxygen saturation up to 74%, pieces of sandwich started to come out of mouth. 911 immediately called. Resident continued to clench teeth and would not allow staff to take out rest of sandwich particles from mouth. Resident began to swallow sandwich particles causing resident to gasp for air, again oxygen saturation decreased to 68%. Began Heimlich maneuver again, more sandwich particles came out. Resident uncooperative with care due to diagnosis of Huntington's. Oxygen saturation up to 78%. Ambulance arrived, blood pressure 159/86, pulse 78, respirations 20, resident left via two attendants on stretcher, alert		compliance for the deficiencies cited. However, submission of this Plan ofCorrection is not an admission that a deficiency exists or that one was citedcorrectly. This Plan of correction is submitted to meet requirementsestablished by state and federal law.	

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	and responsive. Transferred to stretcher, stand/pivot times two attendants." Another entry in Nursing Progress Notes dated 6/8/15 at 3:00 p.m., indicated "Per medical records where entry mentions sandwich particles entry should have been written as food particles. After performing Heimlich for 10-12 minutes on resident, writer was exhausted and immediately after transfer began writing nurses notes to document entire event, during which the mistake of writing sandwich particles instead of food particles was made." Nursing Progress Notes dated 6/6/15 at 2:00 p.m., indicated the resident was admitted to the hospital with the diagnosis of aspiration pneumonia. Nursing Progress Notes dated 6/10/15 at 3:00 p.m., indicated the resident arrived back to facility from the hospital. Hospice was at the facility to admit the resident to their service. Physician Orders on readmit from the hospital dated 6/10/15 from the hospital indicated the resident's diet order was NPO (Nothing by mouth). Following Hospice admission, new Physician Order's dated 6/10/15 at 5:15			

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	p.m., indicated "DC (Discontinue) all labs, Pureed diet with nectar thickened liquids, patient needs to be fed. Small bites only. Supervised only. Crush all meds finely and administer in applesauce." A new care plan dated 6/12/15 was initiated which indicated "High risk for aspiration. Eats food fast and in large amounts. Takes food off other resident's trays as well as dirty food carts." The Nursing interventions were "All staff will monitor resident while up and about and redirect as necessary to prevent him from taking food. Staff will feed resident all meals in small proportion and monitor closely for signs and symptoms of aspiration." Nursing Progress Notes dated 7/15/15 at 1:17 a.m., "Observed resident beginning to aspirate on Unit 3. Writer approached resident to assess resident condition, writer observed resident choking and skin color turning pale. Writer began administering Heimlich maneuver. Unit 4 Nurse entered situation monitoring pulse oximetry which was 65% at 1:20 a.m. 911 called. Continued administering Heimlich maneuver. Intermittent suctioning began with moderate success. Resident began clenching jaws which prevented further			

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	155530	A. BUILDING 00 B. WING	09/22/2015

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	suctioning. Oxygen saturation down to 62%. Second call placed to 911 on location of ambulance. Dispatch explained regular crew on another emergency, have to dispatch another crew. Heimlich maneuver continued with intermittent sweeping of mouth. Removed minor bits of food particles. Intermittent suctioning continued. EMT arrived at 1:35 a.m., and took control of situation and began intubation before transferring resident out of facility to ER." The Emergency room report dated 7/15/15 indicated "The patient was in cardiac arrest upon arrival with ventricular escape rhythm. CPR was in process. The patient did have return of spontaneous circulation prior to arrival. Patient was intubated in route and received no sedation or paralysis. He has had no purposeful movement since return of pulses. Reviewed Physician Order dated 7/15/15 at 5:15 a.m., indicated the resident had expired at the hospital. Interview with LPN #1 on 9/18/15 at 8:50 am indicated the resident did not really have behaviors he just ate really fast and needed to be supervised during meals because he also liked to take food			

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	off resident's meal trays. She indicated the resident was alert enough to know what was going on, he was also ambulatory. Interview with RN #1 the Director of Nursing (DoN) at the time of both choking incidents on 9/18/15 at 9:15 a.m. indicated the resident had Huntington's Chorea and wandered in and out of rooms. He also was observed many times to grab food and drink off of other resident's trays. She indicated after the choking incident on 6/6/15 there was a thorough investigation completed. She indicated the resident was found in his room on the floor. She believed the resident could have wandered into another resident's room and gotten a sandwich and ate it. She indicated the evening snacks were also left at the nurses station so she was not sure where the resident got the sandwich. The DoN knew it was not pureed food the resident had choked on. She indicated there was 1 nurse and 2 CNAS on Unit 3 where the resident resided working that night on the midnight shift. At the time of readmission, his diet order was changed to a pureed diet double portions with nectar thick liquids. The DoN indicated after the incident there was to be no food or drink left on the unit on all shifts. She indicated they kept the resident away			

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	from the main dining room and he was fed in his room by Nursing staff. She indicated after the resident came back he was a little weaker but still was looking for food and was still ambulatory. She indicated the resident was non verbal, did not speak and felt because of his Huntington's he did not always know what he was doing. The DoN indicated the resident was quick and was still able grab food off of trays and put it in his mouth before they could get to him. The DoN indicated there was a plan put into place. She had the Nurse Supervisor on 3-11 shift, to make sure he was not getting into any food left on resident trays. She indicated the 3-11 Nurse Supervisor had a checklist and would complete it and turn it into her every morning on how the meal trays were monitored and picked up after residents were through eating. She indicated there was also a Midnight Supervisor who also monitored the resident and if there was food left out. The DoN indicated the 11-7 Supervisor would give her a verbal report every morning. She also indicated the 3-11 Nurse Supervisor was not allowed to take a Unit or med cart for that very reason to monitor the residents and make sure left over meal trays were not left out and the food was taken back to the kitchen. The DoN indicated all of the written reports and the thorough			

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	investigation of the choking incident on 6/6/15 were unavailable for review. She indicated she had gone on vacation July 1-10 and when came back she was removed as the DoN and was moved to the in house dialysis. She did not know where any of the papers were or where any of the investigations were. She indicated the current Interim DoN was the DoN at the time of the second choking incident and she did not take part in any of that investigation. Interview with LPN #2 on 9/18/15 at 9:35 a.m., indicated he was the nurse taking care of the resident for both choking incidents. He indicated the resident had Huntington's disease and got up frequently at night sometimes more than 20 times a night. LPN #2 indicated the resident was independent for transfers and walked independently as well, however the staff tried to keep him on the unit before he got out of his room. He indicated the resident had a delayed thought process and would stop in the middle of doing things. LPN #2 indicated the first choking incident happened around 1:00 a.m. He indicated the resident got a hold of a sandwich of some sort, because the food that came out of his mouth was not pureed. He indicated he initiated the Heimlich on him and was able to remove the food,			

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	911 was called and he left. The LPN indicated the resident was alert and responsive after the first choking incident. He indicated when the resident came back he was aware of his new diet of pureed food with double portions and thickened liquids and the resident had to be now supervised during meals at all times. The LPN indicated he frequently made rounds up and down the hall during his shift to check on the whereabouts of the resident. He indicated on 7/15/15 before the resident had choked another resident had asked him to assess her and take her vital signs. So he went into the resident's room. LPN #2 indicated the two CNAS assigned to the unit were in other resident rooms doing rounds. The LPN indicated after he was finished with the other resident, he left the room and returned to the nurses station to do charting. Shortly thereafter, he heard someone say "Hey" and at that time, he saw Resident #56 fall to the floor. He indicated the resident was in the intersection of unit 3 and the hallway coming from unit 4. The LPN indicated at that time he called for help and the nurse from unit 4 came down and helped him. 911 was called and he initiated the Heimlich maneuver. He indicated the resident was unresponsive at that time. LPN #2 indicated he had removed food particles from his mouth not pureed food.			

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	He indicated as soon as 911 got there, they took over and intubated the resident. The resident was still unresponsive when he was transferred out of the facility. He indicated later that night, he had found out the resident had taken food off a tray that was left out on unit 4. The LPN indicated there was no midnight supervisor working on 7/15/15. Interview with the Interim DoN who was the Nurse Consultant on 9/18/15 10:00 a.m., indicated there was no written investigation documented or available for review after the resident choked on 6/6/15. She indicated when the Midnight Supervisor was terminated, the investigations with documentation of interviews, witnesses, and interventions disappeared and were nowhere to be found. She further indicated she did not start at the facility until 8/15/15. Interview with the Administrator on 9/18/15 at 10:30 a.m., indicated RN #1 was the DoN at the time of both choking incidents. He indicated there was no 3-11 Supervisor in the facility in June or July 2015. He indicated the Nurse, RN #1 was referring to was just another Nurse, not the Supervisor. He had indicated he had thought the DoN had taken care of the investigation and the plan of action to supervise the resident.			

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	Interview with the Administrator on 9/21/15 at 9:24 a.m., indicated RN #1 was removed as the Director of Nursing on July 13, 2015. He indicated she transferred to the in house dialysis position. The Administrator indicated the current Interim Director of Nursing was the Nurse Consultant during that time, and officially started as the Interim DoN on 8/1/15. The Administrator indicated he had trusted the former DoN to ensure she was doing her job and investigating and determining root cause analysis for all incidents. 3.1-(13)(q)			